

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10896

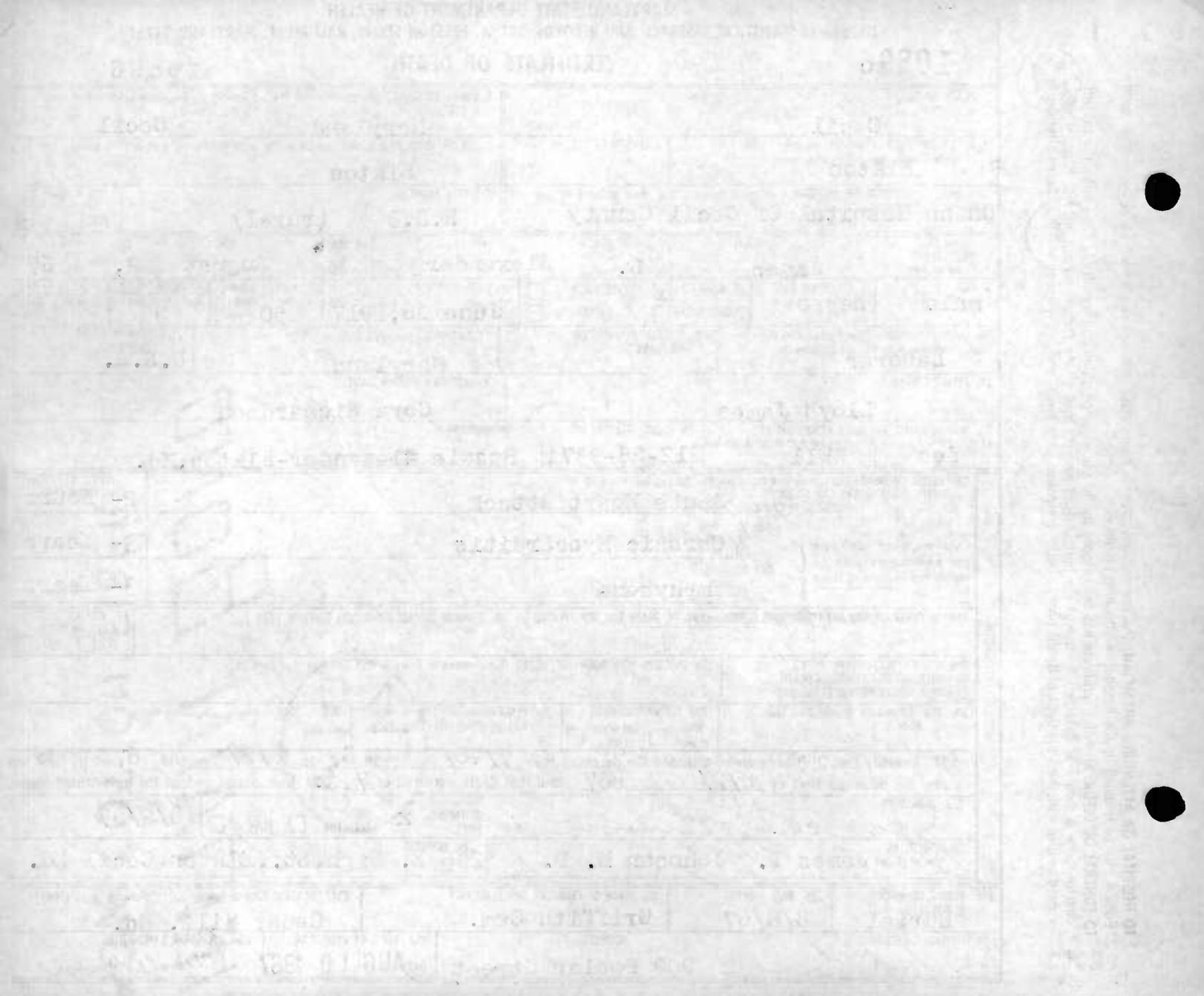
CERTIFICATE OF DEATH

10896

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital Of Cecil County		d. STREET ADDRESS R.D.3 (rural)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James L. Alexander		First James	Middle L.
4. DATE OF DEATH August 2, 1967	Month August	Day 2	Year 1967
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH June 26, 1917
9. AGE (In years lost birthday) 50 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Lloyd James		14. MOTHER'S MAIDEN NAME Cora Richardson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WWII	17. INFORMANT Bessie Alexander-Elkton, Md.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Attack		INTERVAL BETWEEN CONSENT AND DEATH 24 hours	
DUE TO (b) Chronic Myocarditis		3- Years	
DUE TO (c) Emphysema		3- Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 71281
20f. (City or town) Elkton		(County) MD	
(State) MD			
21. I certify that (I) (this hospital) attended the deceased from 7/28/67 , to 8/2/67 , 1967, that (I) (we) last saw the deceased alive on 8/1/67 , 1967, and that death occurred at 7 A.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>James L. Johnson</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) James L. Johnson M. D.		22d. ADDRESS 245 E. High St., Elkton Cecil Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/8/67	23c. NAME OF CEMETERY OR CREMATORIAL Griffith Cem.	23d. LOCATION (City or Town) Cedar Hill, Md.
24. FUNERAL DIRECTOR Clark Bell		ADDRESS 909 Poplar Street	25a. REC'D BY REGISTRAR AUG 10 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10897

10897

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 Wk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Elkton		d. STREET ADDRESS Elkton RD# 4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Earl	Middle H.	Last Anderson	4. DATE OF DEATH Month August	Day 22, 1967	Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1901	9. AGE (In years last birthday) 66 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worked in paper mill		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME L.W. Anderson				14. MOTHER'S MAIDEN NAME Sarah Hash				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Bessie Anderson		Address Elkton, Md. RD# 4		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac arrhythmia DUE TO (c) dilated & fibrotic Heart DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obstructive bronchitis & pulmonary embolism								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 8/16, 1967 to 8/22, 1967 , that I last saw the deceased alive on 8/22, 1967 , and that death occurred at 5 D M, from the causes and on the date stated above.								
ACTUAL SIGNATURE I R Ross M.D.				MEDICAL PRACTICE Elkton, Md.				
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) Reverence, Delaware						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/67		22c. NAME OF CEMETERY OR CREMATORIAL Ott's Chapel Cem.		22d. LOCATION (City, town, or county) Newark, Delaware (State)		
23. FUNERAL DIRECTOR'S SIGNATURE R. T. Jones				ADDRESS Reverence, Delaware		24a. REC'D BY REGISTRAR AUG 25 1967		
						24b. REGISTRAR'S SIGNATURE Charles George		

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MARYLAND STATE DEPARTMENT OF HEALTH
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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 10 days 1 yr 3 mos	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 239 Blakeney Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR Wilson		First ARTHUR	Middle Wilson
4. DATE OF DEATH August 17 1967		Last BARRETT	Month Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-25-00
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Allen Barrett (D)		14. MOTHER'S MAIDEN NAME Adeline Mellor (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 219-16-8053	
17. INFORMANT VA Hospital Records, Perry Point, Md.		18. INTERVAL BETWEEN ONSET AND DEATH 1 hr - 1 day	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli of both lower lobes with recent infarction and right artelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease, severe (c) 		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA Hospital, Perry Point, Md.
20f. (City or town) Perry Point		(County) Md.	
20g. (State) Md.			
21. I certify that XX (this hospital) attended the deceased from May 9, 1966 , to Aug. 17, 1967 to the time of death XX the deceased died XX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX , and that death occurred at 10:15 am from causes and on the date stated above.		22. DATE SIGNED 8-18-67	
22a. SIGNATURE Gladys Ocejo, M.D.		22b. ADDRESS VA Hospital, Perry Point, Md.	
22c. PHYSICIAN'S NAME (Type) GLADYS OCEJO, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 8/21/67		23b. DATE THEREOF BURIAL	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National
23d. LOCATION (City or Town) Baltimore		(County) Md.	
23e. (State) Md.			
24. FUNERAL DIRECTOR MacNabb & Son Funeral Home, Frederick & Wade		25a. REC'D. BY REGISTRAR AUG 22 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

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10899

CERTIFICATE OF DEATH

10899

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To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferry Point		c. LENGTH OF STAY IN lb 9yrs-10mos-7days Chatham				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Sue	Middle R.	Last Becker			
4. DATE OF DEATH August 18,	Month 1967	Doy 19	Year 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-9-94			
9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (County & State, or foreign country) Pickens, Miss.	12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME John Yancy Rainer (Deceased)	14. MOTHER'S MAIDEN NAME Alice Anderson (Deceased)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WWI 213-20-69-37	17. INFORMANT VA Hospital Records - Perry Point, Md.	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, acute severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201			INTERVAL BETWEEN ONSET AND DEATH 1 - 6 hrs			
(b) Broncho pneumonia, right lung DUE TO			2-6 days			
(c) Arteriosclerotic Coronary Heart Disease DUE TO			Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) XX	(County) XX	(State) XX
21. I certify that XX (this hospital) attended the deceased from 10 11 57 , 19 XX , to 8 18 67 , 19 XX , XX , and that death occurred at 8:45 M, from causes and on the date stated above.						
22a. SIGNATURE J.R. Garcia M.D.		22b. DATE SIGNED 8 19 67				
22c. PHYSICIAN'S NAME (Type) JACQUIN GARCIA, M.D.		22d. ADDRESS VA Hospital - Perry Point, Ma.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8-21-1967	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem. Co.	23d. LOCATION (City or Town) Baltimore, Maryland	(County) XX	(State) XX
24. FUNERAL DIRECTOR Charles J. Patterson		ADDRESS PATTERSON FUNERAL HOME - PERRYVILLE, MARYLAND		25a. REC'D BY REGISTRAR Charles J. Patterson	25b. REGISTRAR'S SIGNATURE Charles J. Patterson	
DATE AUG 24 1967						

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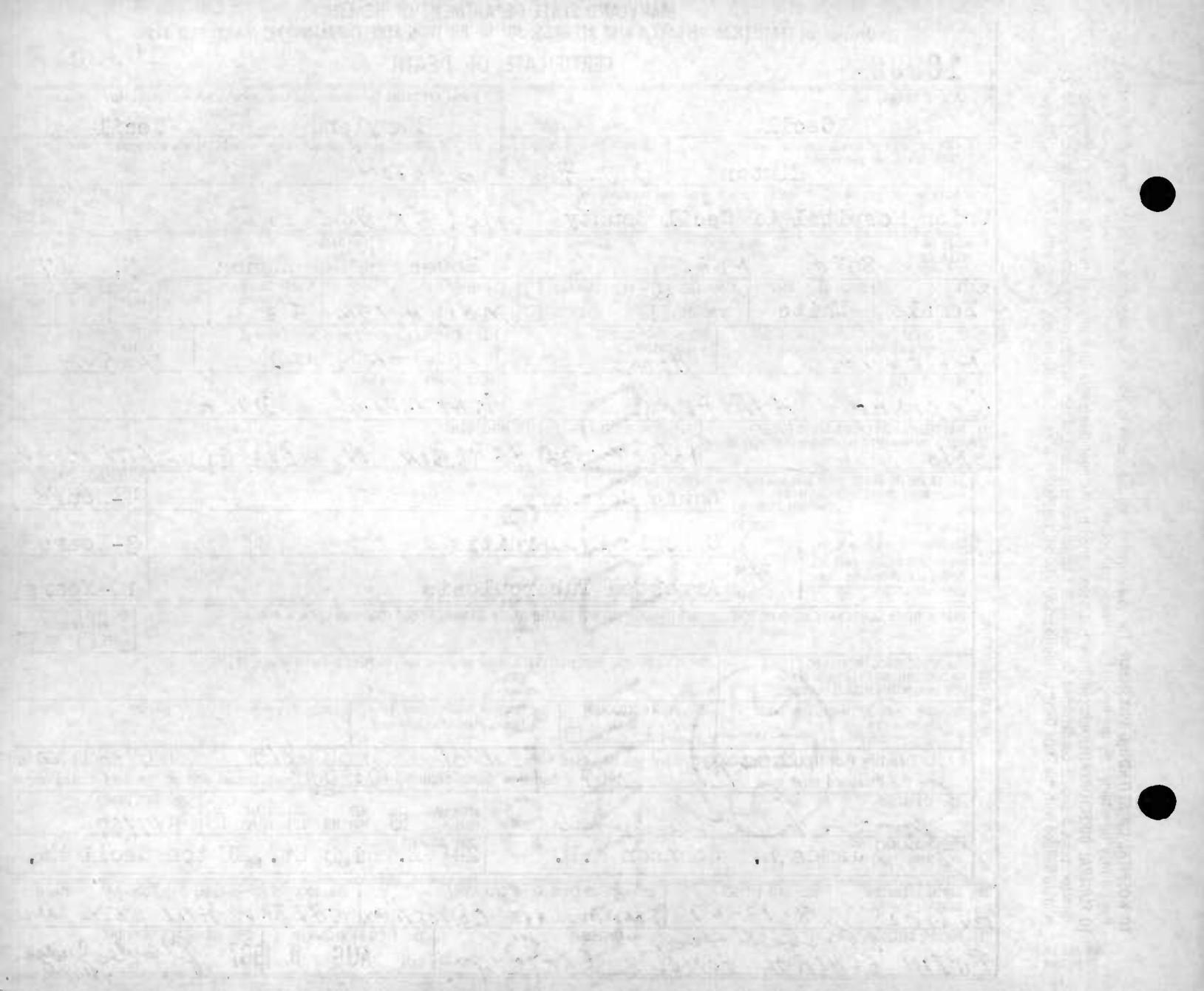
10900

CERTIFICATE OF DEATH

10900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital Of Cecil County		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RITA MAY		First RITA	Middle MAY
4. DATE OF DEATH Month August	Day 5,	Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH May 4, 1914
9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
13. FATHER'S NAME GORMAN HITCHENS	14. MOTHER'S MAIDEN NAME KATHREINE DICK	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 165-07-0926		17. INFORMANT HARRISON N. BOWES, ELKTON, MD.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary		INTERVAL BETWEEN DEATH AND DEATH 4-HOURS	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { (b) Chronic Myocarditis DUE TO (c) Arrested Tuberculosis DUE TO 0082		3-Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 0082
21. I certify that (I) the deceased attended the deceased from 6/23/1967 to 8/5/1967 , that (I) last saw the deceased alive on 8/5/1967 , and that death occurred at 9:30 A.M. from causes and on the date stated above.		22b. DATE SIGNED 8/17/67	
22a. SIGNATURE James L. Johnson		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 E. High St., Elkton Cecil Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-10-67	23c. NAME OF CEMETERY OR CREMATORIAL IMMACULATE CONCEPTION CHERRY HILL CECIL MD.
24. FUNERAL DIRECTOR Robert J. Pippin Funeral Home		ADDRESS ELKTON, MD.	25a. REC'D BY REGISTRAR DATE AUG 9 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



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1
To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

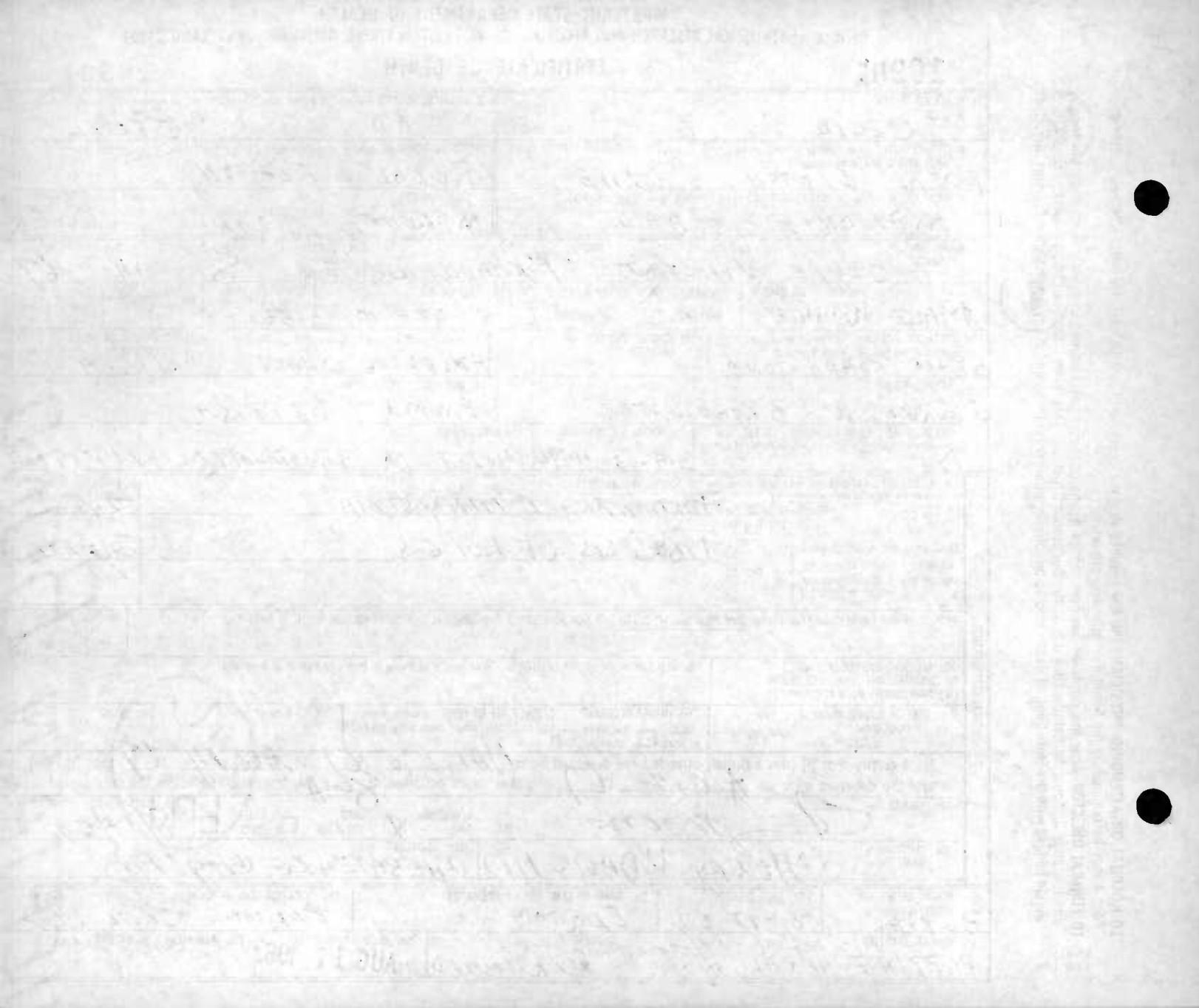
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10901

CERTIFICATE OF DEATH

10901

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ELKTON		c. LENGTH OF STAY IN lb LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ELKTON		d. STREET ADDRESS MALONEY ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALONEY ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLYDE VINCENT BROADWATER		First	Middle	Lost	4. DATE OF DEATH 8 14 1967	Month	Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH 9-27-10	9. AGE (In years lost birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATE ROAD COMM.			10b. KIND OF BUSINESS OR INDUSTRY HOURS DE GRACE		11. BIRTHPLACE (County & State, or foreign country) HOURS DE GRACE		
13. FATHER'S NAME GEORGE W. BROADWATER			14. MOTHER'S MAIDEN NAME EMMA DEPPISH			12. CITIZEN OF WHAT COUNTRY? A. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 219-03-4494			17. INFORMANT VIOLET M. BROADWATER	
Address ELKTON, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMPHYSEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) FIBROSIS OF LUNGS DUE TO lost. (c)							
INTERVAL BETWEEN ONSET AND DEATH 2 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) MARCH 16, 1967		20f. (City or town) (County) (State) ELKTON	
21. I certify that (I) (this hospital) attended the deceased from MARCH 16, 1967 , to APRIL 14, 1967 , that (I) (we) last saw the deceased alive on APRIL 1, 1967 , and that death occurred at ELKTON , from causes and on the date stated above.							
22a. SIGNATURE Henry V. Davis MD							
22b. DATE SIGNED 8/19/67							
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS CHESAPEAKE CITY MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-17-67		23c. NAME OF CEMETERY OR CREMATORIAL ELKTON		23d. LOCATION (City or town) (County) (State) ELKTON CECIL MD.	
24. FUNERAL DIRECTOR Robert J. Faund		ADDRESS PINTIN FUNERAL HOME		25a. REC'D BY REGISTRAR DATE AUG 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10902		10902	
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville d. STREET ADDRESS Elm Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francis Middle Leon Last Campbell		4. DATE OF DEATH Month August Day 31 Year 1967	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 3-26-26 9. AGE (In years last birthday) yrs. 41
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Industry	
13. FATHER'S NAME Albert Campbell		11. BIRTHPLACE (County & State, or foreign country) Perryville, Md. 14. MOTHER'S MAIDEN NAME Wanda Stebbing	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 214-20-2424 17. INFORMANT VA Hospital Records, Perry Point, Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal carcinoma - Floor of mouth 143X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that XX (this hospital) attended the deceased from August 31, 1967 , to August 31, 1967 , XXXXXX and that death occurred at 6:35 PM , from causes and on the date stated above.			
22a. SIGNATURE J. P. BLANCAFLOUR		22b. DATE SIGNED 8/9/67	
22c. PHYSICIAN'S NAME (Type) VAH, Perry Point, Maryland		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/3/1967	
23c. BURIAL CEMETERY OR CREMATORIUM North East Methodist Cemetery		23d. LOCATION (City or Town) (County) (State) North East (Cecil) Maryland	
24. FUNERAL DIRECTOR Lee A. Patterson & Sons, Perry Point, Md.		ADDRESS 25a. REC'D BY REGISTRAR SEP 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Jugeo			

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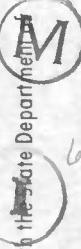
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10903 10903

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CECIL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Virginia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN lb 15 MIN.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JOSEPH E. CHATHAM			First JOSEPH	Middle E.	4. DATE OF DEATH August 27 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-11-06	9. AGE (In years last birthday) 60 YRS. IF UNDER 1 YEAR Months Doy Hours Min.
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY FARM		
13. FATHER'S NAME JOHN CHATHAM			14. MOTHER'S MAIDEN NAME NO INFO.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. —		
17. INFORMANT EMMA MAE CHATHAM			Address TROUT DALE VA.		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arteriosclerotic Cardiovascular Disease					
4221 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause { lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) —				(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>R. Fisher</i>					
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
Address (Street, city, town, or county) —					
22. DATE SIGNED August 28, 1967					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-31-67		23c. NAME OF CEMETERY OR CREMATORIAL CORNERS CREEK	
23d. LOCATION (City or Town) (County) (State) TROUT DALE VA.					
24. FUNERAL DIRECTOR Robert J. Found		ADDRESS PIPPIN FUNERAL HOME		25a. REC'D. BY REGISTRAR AUG 29 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10904

10904

CERTIFICATE OF DEATH

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 should be retained by the hospital or attending physician.	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
a. COUNTY <i>Cecil</i>		a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>North East - Md.</i>		b. COUNTY <i>Cecil</i>	
c. LENGTH OF STAY IN lb <i>2 Mo. 5 da.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North East</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>224 East Main St.</i>		d. STREET ADDRESS <i>R.D. 2</i>	
3. NAME OF DECEASED (Type or print) <i>MARY</i>		4. DATE OF DEATH <i>8 26 1967</i>	
First <i>E.</i>		Last <i>CORNELL</i>	
Middle <i></i>		Month <i>8</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <i>Nov. 11, 1892</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Lancaster Co. Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Singleton</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No (If yes give war or date of service) <i></i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Norman A. Cornell</i>		Address <i>R.D. 2 North East, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic C-v disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>About 2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <i>Parkinson's disease</i>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Time 21....., 1967</i> , to <i>August 26, 1967</i> , that (I) (we) last saw the deceased alive on <i>August 25, 1967</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>10/26/67</i>	
22e. SIGNATURE <i>Ralph Andrews, Jr.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>S. Ralph Andrews Jr.</i>		22d. ADDRESS <i>231 E Main St. - Elkton, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-29-67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Brookview Cemetery Box 22 North East, Md.</i>		23d. LOCATION (City, town or county) <i>Rising Sun, Md.</i> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Paul P. Crandall</i>		25a. REC'D. BY REGISTRAR <i>AUG 29 1967</i>	
Grant Funeral Home		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10905

10905

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 8 mo. 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph		First DAVIS	Middle Last
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3-5-10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Cleaner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Nashville, Tenn		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wyatt Davis		14. MOTHER'S MAIDEN NAME Mary Head	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II		16. SOCIAL SECURITY NO. 406-05-06-94	17. INFORMANT Address VA Hospital Records - Perry Point, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia right lower lobe		INTERVAL BETWEEN ONSET AND DEATH 10-15 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200 DUE TO (b) Emphysema, severe of both lungs		Years	
(c) Arteriosclerotic heart disease		Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES XX NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA Hospital - Perry Point, Maryland
21. I certify that Jarvis Funeral Home attended the deceased from 12-9-66 , 19 pmt 8-13-67 , 19 1000 , and that death occurred at 5:30 M, from causes and on the date stated above.		20f. (City or town) Landover (County) Maryland (State)	
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 8-13-67	
22c. PHYSICIAN'S NAME (Type) Seymour Goldgraben, M.D.		22d. ADDRESS VA Hospital - Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/18/1967	23c. NAME OF CEMETERY OR CREMATORIUM Harmony
24. FUNERAL DIRECTOR Jarvis Funeral Home		ADDRESS home	25a. REC'D BY REGISTRAR Charles Judge
			25b. REGISTRAR'S SIGNATURE
			AUG 16 1967

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10906 10906

CERTIFICATE OF DEATH

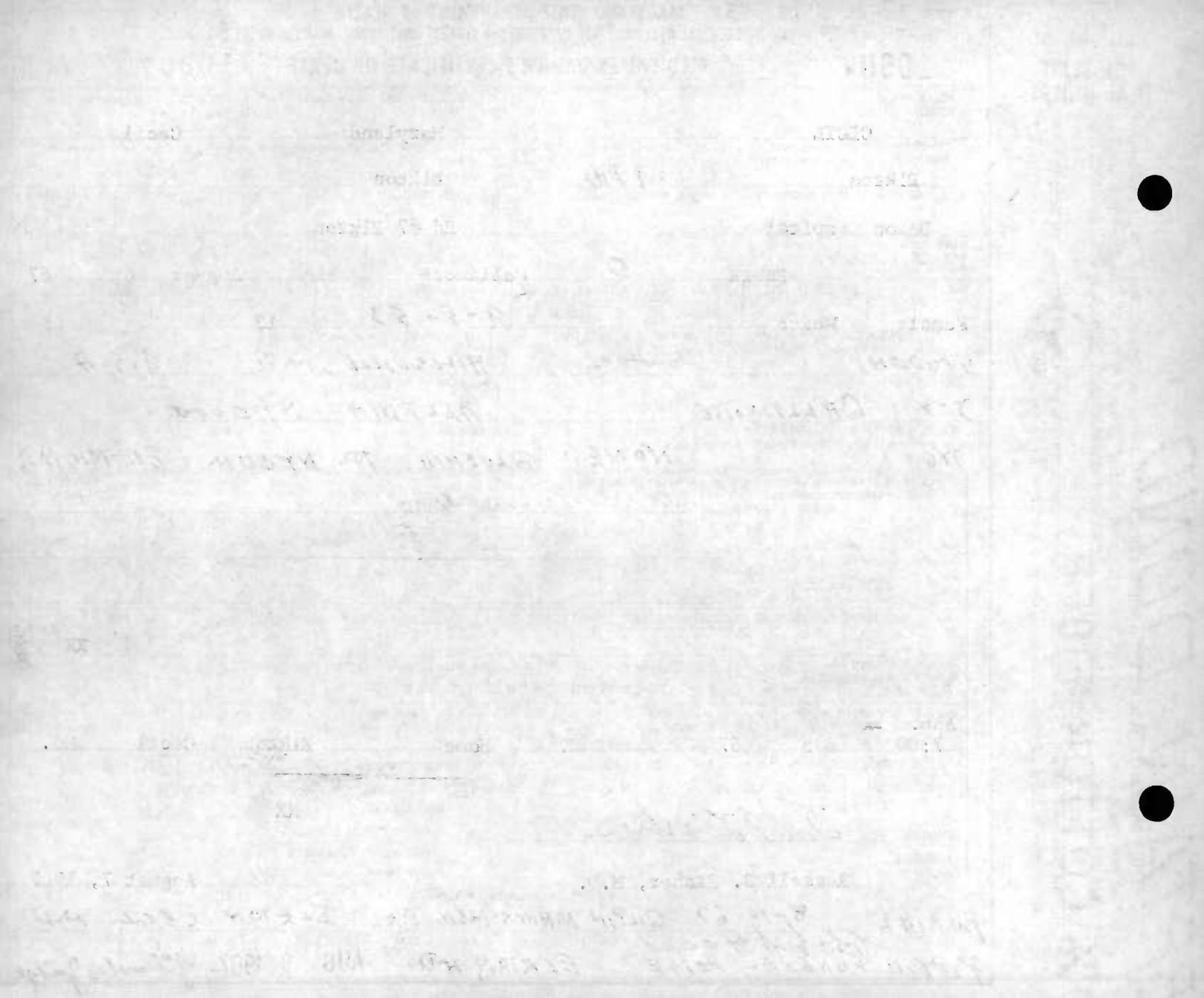
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital			d. STREET ADDRESS R.D. 4		Aug. 3 1967
3. NAME OF DECEASED (Type or print)	First Ray	Middle Richard	Last Dean	4. DATE OF DEATH	Month Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 18, 1912	9. AGE (In years last birthday) 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Concrete		11. BIRTHPLACE (County & State, or foreign country) Pocahontas Co. W Va.	
13. FATHER'S NAME Edgar W. Dean			14. MOTHER'S MAIDEN NAME Pearl E. Cuttipe		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 233-16-1626		17. INFORMANT Charles B. Dean	
Address R.D. 2 North East, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Subtotal Gastrectomy on 8-2-67. DUE TO last (c)					
INTERVAL BETWEEN ONSET AND DEATH 24 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subtotal Gastrectomy on 8-2-67.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-1-1967 , to 8-3-1967 , that (I) (we) last saw the deceased alive on 8-3-1967 and that death occurred at 940 M. from causes and on the date stated above.					
22a. SIGNATURE Cristobal Vega		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8-3-67		
22c. PHYSICIAN'S NAME (Type) CRISTOBAL VEGA		22d. ADDRESS 123 W. High St. Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-7-67	23c. NAME OF CEMETERY OR CREMATORIAL PARK Gilpin Manor Mem. Park	23d. LOCATION (City or Town) Elkton	(County) Cecil
24. FUNERAL DIRECTOR Paul R. French Grant Funeral Home		ADDRESS Box 22 North East, Md.	25a. REG'D BY REGISTRAR AUG 7 1967	25b. REGISTRAR'S SIGNATURE Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1-2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10907		MEDICAL EXAMINER'S CERTIFICATE OF DEATH					10907			
1. PLACE OF DEATH o. COUNTY CECIL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 1 DAY			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital			d. STREET ADDRESS Rd #7 Elkton			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) BESSIE			First O.	Middle	Last	4. DATE OF DEATH Gallimore	Month August	Doy 6	Year 1967	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-5-53	9. AGE (In years lost birthday) 13 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT			10b. KIND OF BUSINESS OR INDUSTRY SCHOOL			11. BIRTHPLACE (State or foreign country) HILLSVILLE, M.D.	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN GALLIMORE			14. MOTHER'S MAIDEN NAME ALVENIA NYCOM			Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE			17. INFORMANT ALVENIA NYCOM	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Barbiturate ingestion DUE TO 970.2 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Ingested barbiturates			21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Noturol causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year App. Hour 7:00 p.m. 8 5 1967			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Elkton Cecil Md.					
ACTUAL SIGNATURE <i>Russell S. Fisher</i>			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.			22. DATE SIGNED August 7, 1967				
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 8-10-67			23c. NAME OF CEMETERY OR CREMATORIAL GILPIN MANOR MEM. PK.			23d. LOCATION (City or Town) (County) (State) ELKTON CECIL MD.	
24. FUNERAL DIRECTOR Robert F. Fawcett			ADDRESS PIPPIN FUNERAL HOME			25a. REC'D BY REGISTRAR AUG 9 1967			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

M
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10908

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10908

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>WEST VIRGINIA</u> b. COUNTY <u>JEFFERSON</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>	c. LENGTH OF STAY IN lb <u>2 DAYS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHARLESTOWN - RURAL</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>	e. STREET ADDRESS <u>STILES TRAILER COURT</u>	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>PERLE MASON</u>	First <u>GEORGE</u> Middle <u>GEORGE</u> Lost	4. DATE OF DEATH <u>AUG 13 1967</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 24 1918</u>	9. AGE (In years last birth day) <u>48</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u> Dots <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Dots <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LACRER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>R&O RAILROAD</u>	11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>CHARLES GEORGE</u>	14. MOTHER'S MAIDEN NAME <u>LUCRETIA MAYLES</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>MRS. P.M. GEORGE</u>	Address <u>CHARLESTOWN W. VA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>CORONARY THROMBOSIS</u> DUE TO <u>CHRONIC CORONARY DISEASE</u> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. <u>4201</u>				INTERVAL BETWEEN ONSET AND DEATH <u>INST</u>		
DUE TO <u>CHRONIC CORONARY DISEASE</u> (c)				SEVERAL YEARS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL OVER AT HOME SHORTLY AFTER EATING</u>					
20c. TIME OF INJURY Month, Day, Year <u>625 p.m. 8/13/67</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>AT HOME</u>	20f. (City or Town) <u>ELKTON</u>	(County) <u>ROCKAWAY</u>	(State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <u>HENRY V. DAVIS</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>HENRY V. DAVIS M.D.</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE THEREOF <u>AUG. 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>ELKTON, MD</u>	23d. LOCATION (City or Town) <u>CHARLESTOWN, W. VA</u>	(County) <u>CHARLESTOWN</u>	(State) <u>W. VA</u>	
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>	ADDRESS <u>Dorothy De</u>	25a. REC'D BY REGISTRAR <u>AUG 15 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Patricia J. De</u>			

3
1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove ~~copy~~ ~~copy~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

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10905

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10909

1. PLACE OF DEATH o. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY <i>Allentown ✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 42 yrs 45 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 01-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 219 Maryland Avenue			
3. NAME OF DECEASED (Type or print) GELSON		First L.	Middle GRADY	Lost	4. DATE OF DEATH August 2 1967	Month August	Doy Year 2 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-95	9. AGE (In years last birthday) yrs. 72	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Grady (D)				14. MOTHER'S MAIDEN NAME Ella Wright (D)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>If yes give war or dates of service</i> Yes WW I		16. SOCIAL SECURITY NO. 217-54-9846		17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 4200		VENTRICULAR fibrillation				INTERVAL BETWEEN ONSET AND DEATH Sudden	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b)		Arteriosclerotic heart disease				years	
(c)		Arteriosclerosis, generalized				years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Cerebral arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (D) (this hospital) attended the deceased from June 27, 1967 , to Aug. 1, 1967 , and that death occurred on Aug. 1, 1967 , and that death occurred on 2:25 P.M. from causes and on the date stated above.							
22a. SIGNATURE A. L. Mooney						22b. DATE SIGNED 8-2-67	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 4, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR PATTERSON FUNERAL HOME		ADDRESS Perryville, Md.		25a. REC'D. BY REGISTRAR AUG 7 1967		25b. REGISTRAR'S SIGNATURE <i>James J. Mooney</i>	
				DATE			

1980-10-24 14:14:23

Безопасность выработки и ее стабильность

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

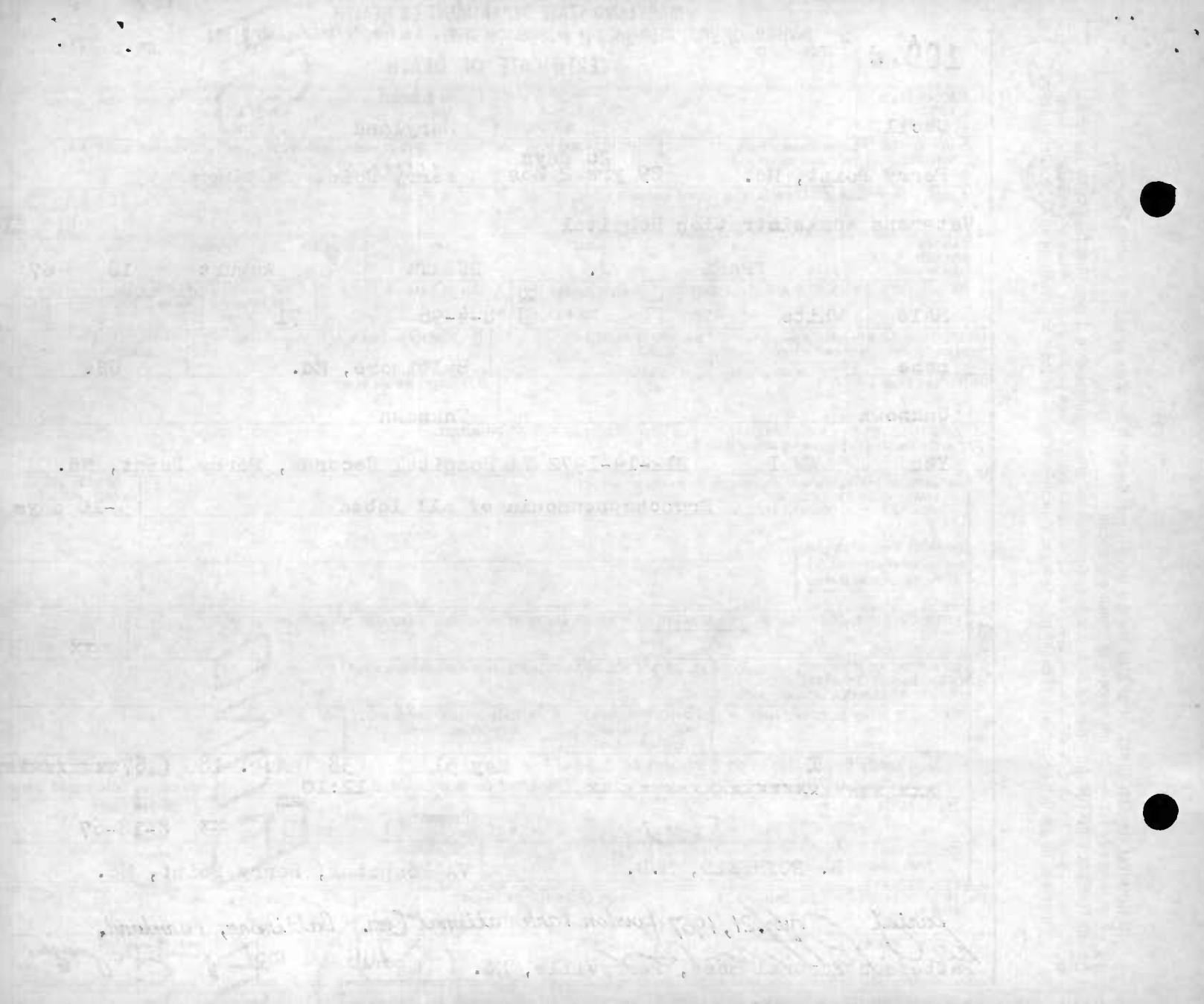
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2c Film #G392 8/29/67 ph

10910

CERTIFICATE OF DEATH

10910

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 26 days 29 yrs 2 mos		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS —		
3. NAME OF DECEASED (Type or print) FRANK J. HUBATA		4. DATE OF DEATH August 18 1967	Month Doy Year	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-96	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 71 yrs.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 212-14-1972	17. INFORMANT VA Hospital Records, Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 4-10 days		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia of all lobes				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ (c) _____		DUE TO DUE TO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 31 , 19 38 , to Aug. 18 , 19 67 , and <input checked="" type="checkbox"/> saw the deceased alive on xxxxxxxxxxxxxx , and that death occurred at 12:10 , from causes and on the date stated above.				21b. DATE SIGNED 8-18-67
22a. SIGNATURE B. Rothfeld		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 8-18-67
22c. PHYSICIAN'S NAME (Type) B. ROTHFELD, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 21, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Boudon Park National Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md.		ADDRESS	25a. RECD. BY REGISTRAR AUG 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if applicable, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10911

CERTIFICATE OF DEATH

10911

1. PLACE OF DEATH o. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 28 8th Street, NE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ALEXANDER		First	Middle	Last	4. DATE OF DEATH August 23 1967	Month	Doy	Year
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-12	9. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Orange Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert Johnson		(D)		14. MOTHER'S MAIDEN NAME Doretha Johnson		(D)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 578-12-1936		17. INFORMANT VA Hospital Records, Perry Point, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant cachexia INTERVAL BETWEEN ONSET AND DEATH 157X weeks DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Carcinomatosis weeks DUE TO (c) Carcinoma of pancreas with metastasis 1/2-1 year								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)		
21. I certify that VA Hospital attended the deceased from July 26 1967 , to Aug. 23, 1967 , shortly before last sex the deceased died on xxxxxx xxxxx , and that death occurred at 06:05 AM from causes and on the date stated above.								
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/26/67	23c. NAME OF CEMETERY OR CREMATORIUM Harmont		23d. LOCATION (City or Town) (County) (State) Ogco. Md			
24. FUNERAL DIRECTOR John T. Rhines Funeral Home, Washington, DC		ADDRESS		25a. REC'D BY REGISTRAR John T. Rhines		25b. REGISTRAR'S SIGNATURE Charles Judge		
25m 1/67		DATE AUG 28 1967						

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10912

CERTIFICATE OF DEATH

10912

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHESTER		First ARTHUR	Middle KENNEDY
4. DATE OF DEATH Month 8	Day 9	Year 1967	5. SEX M
6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-82
	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 85	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER	10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (County & State, or foreign country) WILMES CO. N.C	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME NEWTON KENNEDY	14. MOTHER'S MAIDEN NAME JANE HALL	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 200-10-5273		17. INFORMANT JULIUS A. JODLBALER	Address ELKTON MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease			
4200 DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause last. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat White <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) ELKTON (County) MARYLAND (State) MD			
21. I certify that (I) (this hospital) attended the deceased from 8-3- , 19 67 , to 8-5- , 19 67 , that (I) (we) last saw the deceased alive on 8-9- 1967 , and that death occurred at 2 A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Tillman D. Johnson</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8-10-67
22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson		22d. ADDRESS 123 Singlet Ave. Elkton	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-12-67	23c. NAME OF CEMETERY OR CREMATORIAL ROSE BANK
24. FUNERAL DIRECTOR Robert P. Johnson		23d. LOCATION (City or Town) (County) (State) CALVERT CECIL MD.	
ADDRESS PIPPIN FUNERAL HOME ELKTON, MD		25a. REG'D BY REGISTRAR AUG 14 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10913

CERTIFICATE OF DEATH

(10913)

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CECIL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY CECIL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN lb 12 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON MD		d. STREET ADDRESS 303 ELKTON BLVD		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) HELEN		First	Middle H.	Lost	4. DATE OF DEATH 8 - 17 1967	Month	Day Year 1967	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-93	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NO HOME		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES HAMILTON		14. MOTHER'S MAIDEN NAME MARGARET FLOSSER						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 203-03-5921		17. INFORMANT UNION HOSPITAL		Address Hospital Records ELKTON MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A.		DUE TO (b) HYPERTENSIVE C.V.DISEASE		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 100 DAYS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July 10, 1967 , to Aug. 17, 1967 , that (I) (we) last saw the deceased alive on Aug 17 1967 and that death occurred at 5 AM , from causes and on the date stated above.								
22a. SIGNATURE Henry V. Davis		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) HENRY V. DAVIS		22d. ADDRESS CHESAPEAKE CITY MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG. 19, 1967		23c. NAME OF CEMETERY OR CREMATORIUM GILPIN MANOR MEM PH.		23d. LOCATION (City or Town) (County) (State) ELKTON, CECIL MD		
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		ADDRESS Elkton, Md		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 20 M 1/66		DATE AUG 21 1967						

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
o. COUNTY <u>Cecil</u> MARYLAND		o. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. LENGTH OF STAY IN lb <u>8 yrs, 1M. 9 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SCHUYLER</u>		First <u>C.</u>	Middle <u>MARSHALL</u>
Last <u>Rachel Wilson</u>		4. DATE OF DEATH <u>August 30 1967</u>	Month Day Year
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>9-30-25</u>		9. AGE (In years last birthday) <u>41 yrs.</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chaplain</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Patterson, New Jersey</u>
13. FATHER'S NAME <u>Schuyler Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>150-12-1781</u>	17. INFORMANT Address <u>VA Hospital Records, Perry Point, Md.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Ventricular Fibrillation</u> DUE TO 4331 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Insufficiency</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <u>VAH, Perry Point, Md.</u>
20f. (City or town) (County) (State)			
21. I certify that <u>Q. L. Mooney</u> (this hospital) attended the deceased from <u>November 10, 1958</u> , to <u>August 30, 1967</u> , and that death occurred at 2:15 am from causes and on the date stated above.			
22a. SIGNATURE <u>A. L. MOONEY, M.D.</u>		22b. DATE SIGNED <u>8-30-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>VAH, Perry Point, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>29A/1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Baltimore National Cemetery Baltimore, Md.</u>
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <u>Patterson Funeral Home, Perryville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 6 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE
HEALTH DEPT.

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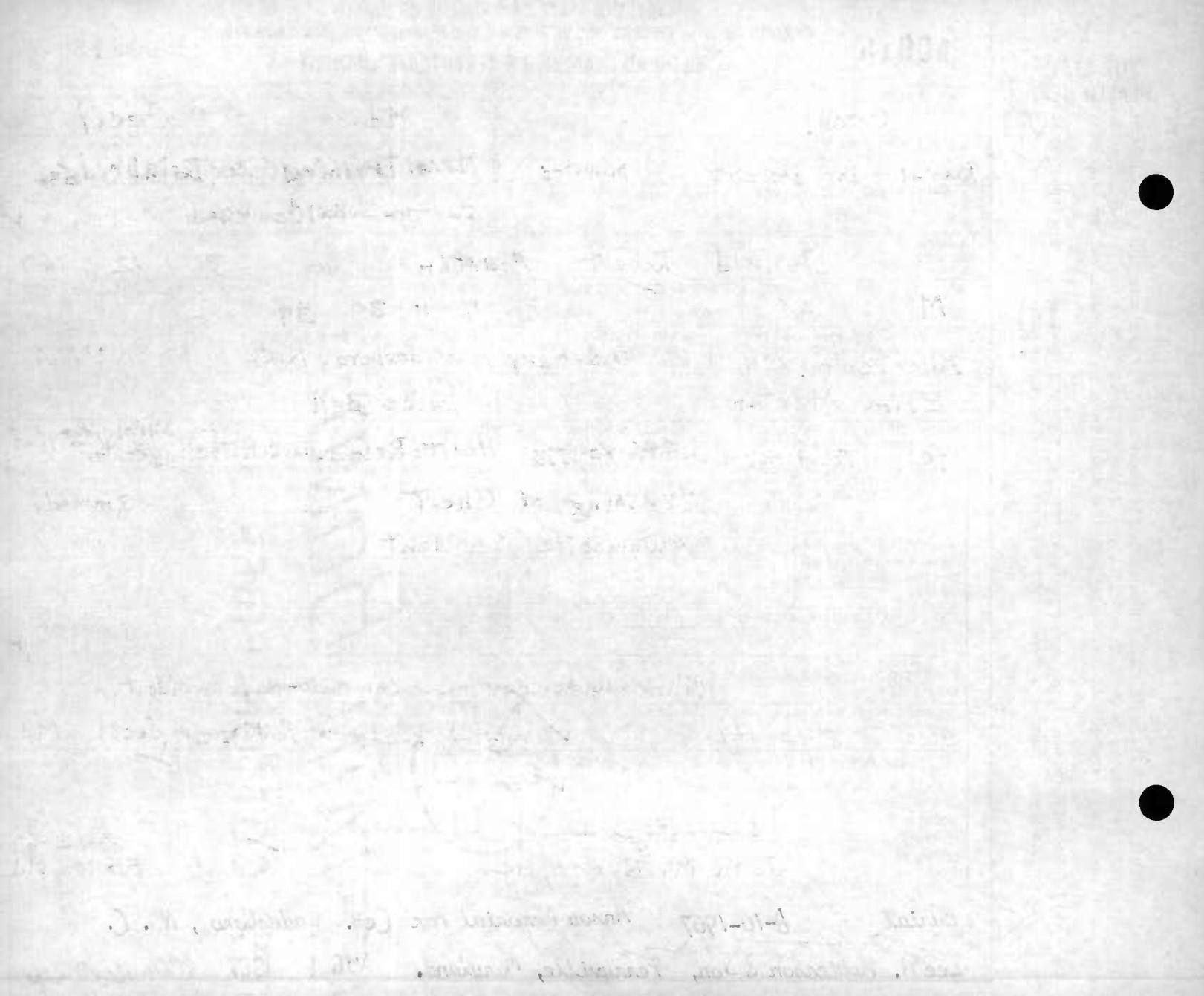
1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10915 10915

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Port Deposit</i>		c. LENGTH OF STAY IN 1b <i>minutes</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Donald Robert Martin</i>		4. DATE OF DEATH Month <i>8</i> Day <i>12</i> Year <i>1967</i>	e. IF UNDER 1 YEAR Months <i>00</i> Days <i>00</i> Hours <i>00</i> Min. <i>00</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-11-30</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Boiler Tender, U.S.N.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Navy</i>	9. AGE (In years (last birthday) yrs. <i>37</i>)
13. FATHER'S NAME <i>Elim Martin</i>		11. BIRTHPLACE (State or foreign country) <i>Wadesboro, N.C.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> <i>Feb. 9, 1967 - 3 yrs.</i>		16. SOCIAL SECURITY NO. <i>244-70-7876</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crushing of Chest</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Automobile Accident</i> DUE TO (c)		17. INFORMANT Address <i>Bainbridge, Md.</i> <i>Health Record, U.S.N. Training Center</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Pinned under car in one-car automobile accident.</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>9:10</i> p.m. <i>8-12 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Craigtown Road</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		20f. (City or town) <i>Port Deposit, Cecil, Md.</i> (County) <i>MD.</i> (State) <i>Md.</i>	
ACTUAL SIGNATURE <i>John M. Byers, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John M. Byers, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-16-1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Anson Memorial Park Cemetery, Wadesboro, N.C.</i>
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Perryville, Maryland.</i>		ADDRESS	25a. REC'D BY REGISTRAR
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10916

CERTIFICATE OF DEATH

10916

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 2 Mo 9 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Md.		e. STREET ADDRESS 3701 S. 13th Street	
3. NAME OF DECEASED (Type or print) JOSEPH		First F	Middle MASSEY
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8. DATE OF BIRTH 5-12-98		9. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic - Retired		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (County & State, or foreign country) Hampton, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Massey		14. MOTHER'S MAIDEN NAME Mary D. Foster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 225-05-2741	
17. INFORMANT VA Hospital records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Atelectasis, Right Lung		INTERVAL BETWEEN ONSET AND DEATH 2-3- Hrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 150X			
(b) Metastatic Tumor nodule to Lungs, Bilateral		Months	
DUE TO			
(c) Carcinoma of Esophagus.		1-2 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town) VAH. (County) Perry Point, Md. (State)	
21. I certify that (I) (this hospital) attended the deceased from June 5 , 19 67 , to August 14 , 19 67 , and that death occurred at 4:00PM , from causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 8-14-67	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d. ADDRESS VAH., Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Removal		23b. DATE THEREOF 8/27/67	23c. NAME OF CEMETERY OR CREMATORIAL Culpepper National Cem.
23d. LOCATION (City or Town) Culpepper, Virginia		(County) Charles Judge (State)	
24. FUNERAL DIRECTOR W. J. McDonay		25a. REC'D BY REGISTRAR DATE AUG 17 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	
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Editor - John E. G.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10917

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10917

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb P.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS		First McANDREW	Middle Last Month Year August 25 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES REPRESENT		10b. KIND OF BUSINESS OR INDUSTRY SALES	9. AGE (In years last birthday) 45 yrs.
13. FATHER'S NAME JAMES P. MC ANDREW		11. BIRTHPLACE (State or foreign country) JESSUP PA.	12. CITIZEN OF WHAT COUNTRY? A.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	14. MOTHER'S MAIDEN NAME EVA KELLY
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: 416X IMMEDIATE CAUSE (o) Rheumatic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Address ANN MARIE WRIGHT GLENOLDEN, PA.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Russell S. Fisher</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		Address (Street, city, town, or county) Scranton PA.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-29-67	23c. NAME OF CEMETERY OR CREMATORIAL CATHEDRAL
24. FUNERAL DIRECTOR Robert J. Fisher		23d. LOCATION (City or Town) (County) (State) ELKTON, MD.	
ADDRESS TIPPIN FUNERAL HOME		25a. RECD BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10918 10918

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MD b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 2 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON 07-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL			d. STREET ADDRESS 207 FRIENDSHIP ROAD			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ANNA		First B.	Middle PRICE	Lost	4. DATE OF DEATH 8 17 1967	Month Doy Year
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-90		9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICAL NURSE		10b. KIND OF BUSINESS OR INDUSTRY NURSING		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? A.S.A.
13. FATHER'S NAME HOUGH		14. MOTHER'S MAIDEN NAME MARGARET			Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT MARGARET A. APPLEFORD, ELKTON, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon & Metastases						INTERVAL BETWEEN ONSET AND DEATH EST-6 mos.
1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) DUE TO _____ (d) DUE TO _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Elkton (County) Carroll (State) M.D.
21. I certify that (I) (this hospital) attended the deceased from 6-29- , 1967 to 8-12- , 1967, that (I) (we) last saw the deceased alive on 8-17-1967 , and that death occurred at 10:00 P.M. from causes and on the date stated above.						22b. DATE SIGNED 8-18-67
22c. PHYSICIAN'S NAME (Type) T.D. Johnson		22d. ADDRESS 123 Singlety Ave Elkton Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-21-67		23c. NAME OF CEMETERY OR CREMATORIAL G'LPIN MANOR MEM. PR. ELKTON		23d. LOCATION (City or Town) Elkton (County) Carroll (State) M.D.
24. FUNERAL DIRECTOR Robert J. Johnson		ADDRESS PIPPIH FUNERAL HOME ELKTON, MD.		25a. REC'D BY REGISTRAR Judge		25b. REGISTRAR'S SIGNATURE Judge
VR A15 (4) 20 M 1/66				DATE AUG 21 1967		

Carrying out the following

520-88-8

DOOR

2865

REASON

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10919

1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10016			
1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 104 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia	
f. STREET ADDRESS 303 North 5th Street		g. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John J. REILLY		4. DATE OF DEATH Month August Day 7 , Year 1967	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 28 07	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Reilly (D)		14. MOTHER'S MAIDEN NAME Mary Tireny (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) Yes (If yes give war or dates of service) WW II		16. SOCIAL SECURITY NO. 160-01-10-69	
17. INFORMANT VA Hospital Records - Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4 25 67 , 19 67 , to 8 7 67 , 19 67 , and that death occurred at 10:15 A.M. from causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 8 8 67	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. ADDRESS VA Hospital - Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-12-67	
23c. NAME OF CEMETERY OR CREMATORIAL Hillside Cemetery		23d. LOCATION (City or Town) (County) (State) Roslyn, Pa.	
24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md.		25a. REC'D BY REGISTRAR DATE AUG 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10920

CERTIFICATE OF DEATH

10920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John W. SCHAIBLE		4. DATE OF DEATH Month August Day 10, Year 1967	e. IS RESIDENCE ON A FARM? IF UNDER 1 YEAR Months 07 Days 7 Hours 00 Min. 00
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 14 97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maint.		10b. KIND OF BUSINESS OR INDUSTRY School Board	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
13. FATHER'S NAME Christian Schaible		14. MOTHER'S MAIDEN NAME Pauline---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 215-01-14-96	17. INFORMANT Address VA Hospital Records - Perry Point, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, all lobes DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease, severe DUE TO Many years (c)			
INTERVAL BETWEEN ONSET AND DEATH 5 - 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 8-8-67
20f. (City or town) 8-10-67		(County) 19 (State)	
21. I certify that Benjamin Rothfeld (this hospital) attended the deceased from 8-8-67 , 19, to 8-10-67 , 19, and that death occurred at 7:55 PM , from causes and on the date stated above.			
22a. SIGNATURE Benjamin Rothfeld		22b. DATE SIGNED 8-11-67	
22c. PHYSICIAN'S NAME (Type) BENJAMIN ROTHFELD, M.D.		22d. ADDRESS VA Hospital - Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/14/67	23c. NAME OF CEMETERY OR CREMATORIAL Cherry Hill Cemetery
23d. LOCATION (City or Town) Cherry Hill, Md.		(County) 19 (State)	
24. FUNERAL DIRECTOR Ralph E. Hicks HICKS FUNERAL HOME - ELKTON, Maryland		ADDRESS 25a. REC'D BY REGISTRAR DATE AUG 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

10921

CERTIFICATE OF DEATH

10921

1. PLACE OF DEATH o. COUNTY Cecil			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ o. STATE District of Columbia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 4 days 25 yrs 2 mos		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			e. STREET ADDRESS 775 Fairmont St., NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) EDWARD		First EDWARD	Middle 	Last TURNER	4. DATE OF DEATH August 14 1967
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-89	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, DC	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 217-54-9829	17. INFORMANT VA Hospital Records, Perry Point, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Heart Disease } Unkn (b) Arteriosclerosis, Generalized } DUE TO (c) Arteriosclerosis, Generalized } Years					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Arteriosclerosis.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) May 21, 1942	(County) (State) Aug. 14, 1967
21. I certify that 11 (this hospital) attended the deceased from May 21, 1942 , to Aug. 14, 1967 , not xx xx say the deceased alive on xxxxxxxxxxxxxx , and that death occurred at 9:45 AM , from causes and on the date stated above					
22a. SIGNATURE A. L. Mooney		MD	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/18/1967	23c. NAME OF CEMETERY OR CREMATORIUM Lincoln	23d. LOCATION (City or Town) Suitland, Maryland	
24. FUNERAL DIRECTOR Jarvis Funeral Home		ADDRESS Jarvis Funeral Home, 1432 You St., NW, Wash.	DC	25a. REC'D BY REGISTRAR DATE AUG 16 1967	25b. REGISTRAR'S SIGNATURE Mooney, A. L.

475-22 JOURNAL

AUGUST

PROBLEMS OF PRACTICE

SCHOOL CHILDREN'S CONCERN

ADOLESCENT AIR TO AIR MEDIC

ADOLESCENT PRODUCT INFORMATION

ADOLESCENT

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10822

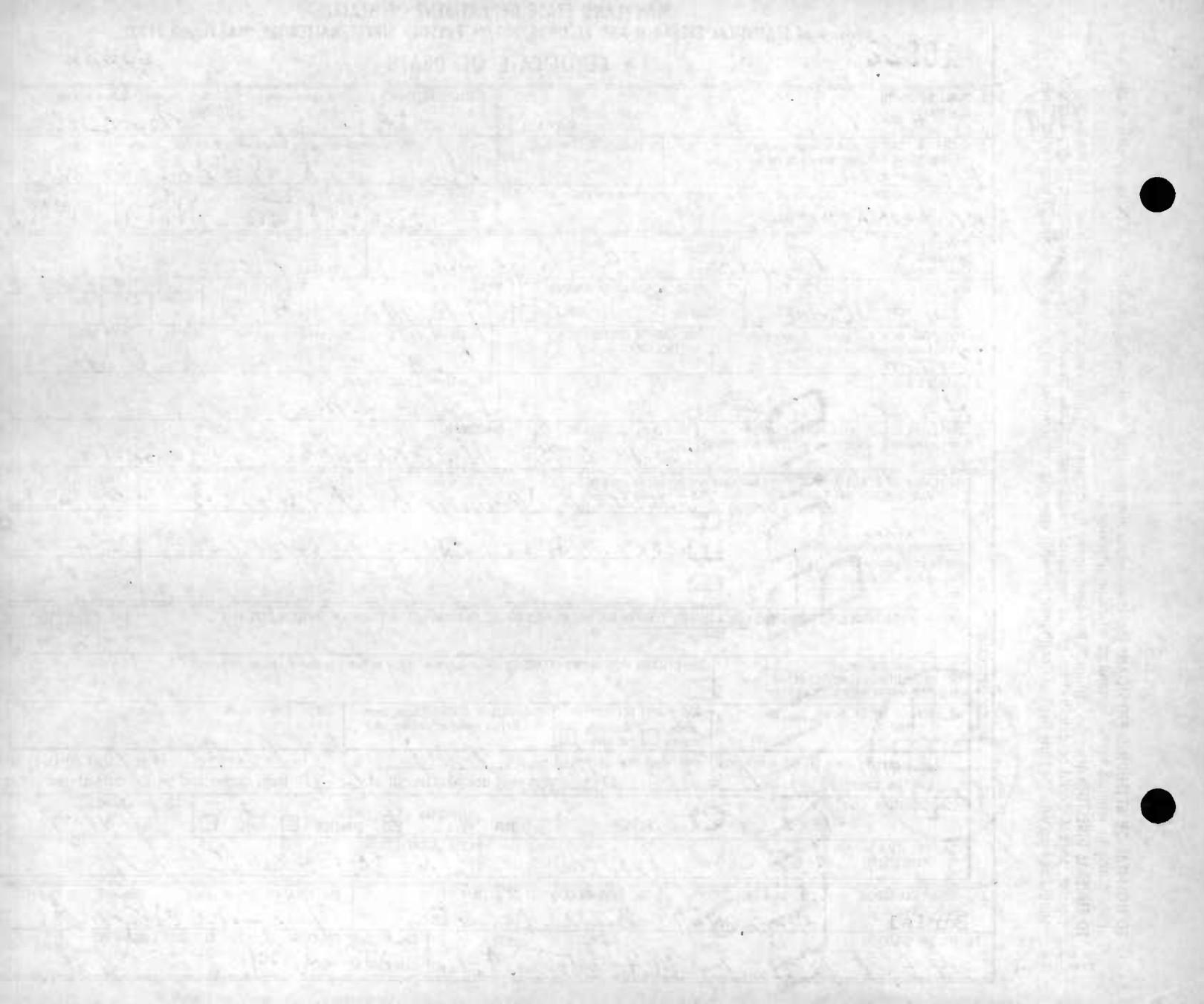
10922

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Tel.</i>		b. COUNTY <i>Newcastle</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Summit Bridge</i>		d. STREET ADDRESS <i>Middletown R.D.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>UNION HOSPITAL</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>CLAUDE</i>	Middle <i>B.</i>	Lost <i>VOSHELL</i>	4. DATE OF DEATH Month <i>August</i>	Year <i>21</i>	Doy <i>1967</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/16/94</i>	9. AGE (In years last birthday) <i>73 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Delaware</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Harry Voshell</i>		14. MOTHER'S MAIDEN NAME <i>Louie Davis</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>222-14-0095</i>		17. INFORMANT <i>Hosp Records</i>		Address <i>Elkton MD</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured Abdominal Aneurysm</i>		DUE TO <i>451X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i></i>		(b) DUE TO <i>Arteriosclerosis: Generalized</i>		SEVERAL YEARS			
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 1</i> , 19 <i>67</i> to <i>Aug 21</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Aug 21</i> , 19 <i>67</i> , and that death occurred at <i>Chesapeake Cem.</i> from causes and on the date stated above.							
22a. SIGNATURE <i>Henry V. Davis</i>		M.D. <input type="checkbox"/>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>Sept 1/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Henry V. Davis</i>		22d. ADDRESS <i>Chesapeake Cem. 170</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug 24, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Chesapeake City, Md.</i>	
24. FUNERAL DIRECTOR <i>G. Lester Daniels</i>		ADDRESS <i>Middletown Del.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE	
				DATE AUG 25 1967			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

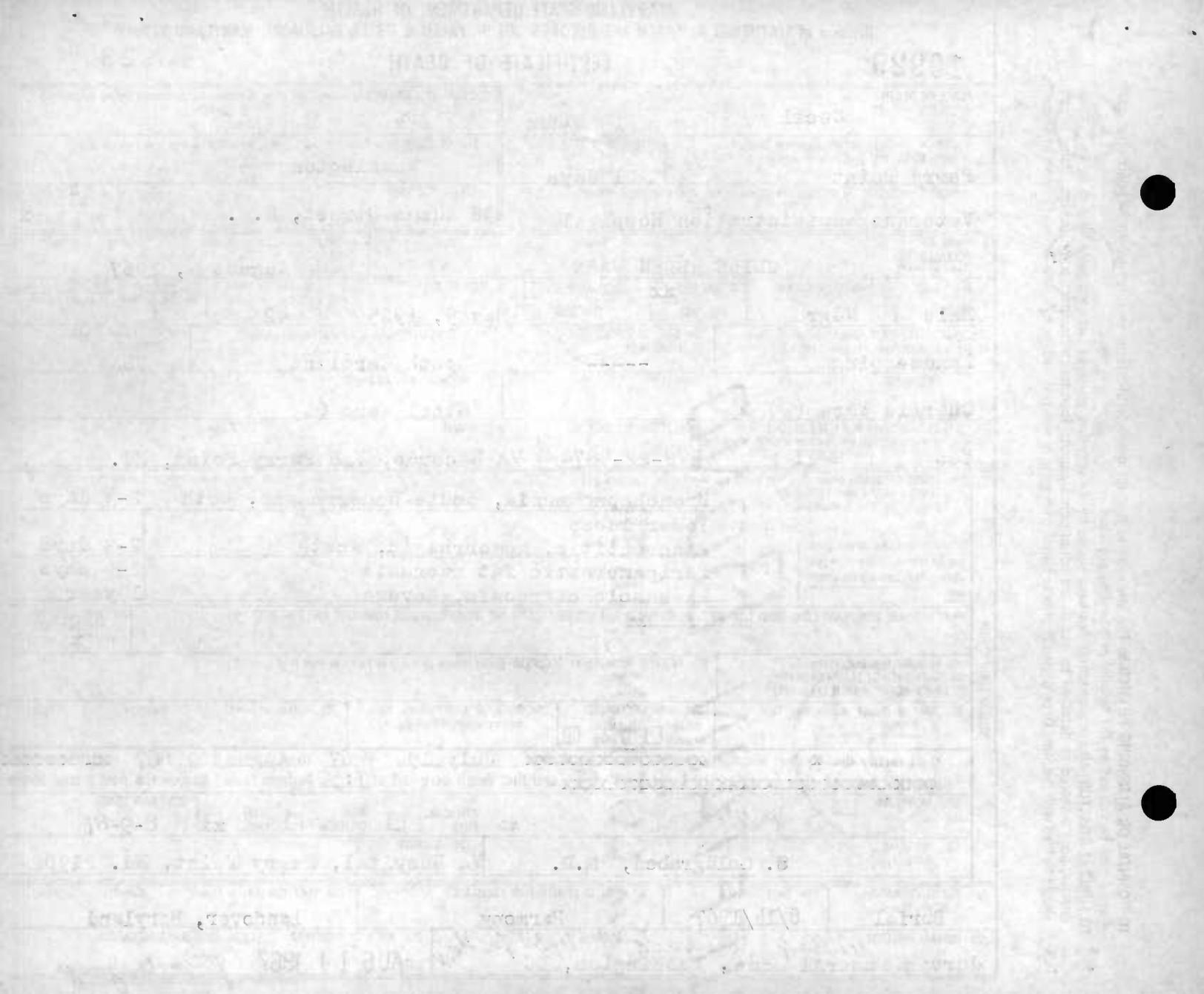
10923

CERTIFICATE OF DEATH

10923

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DC	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 21 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print) CLYDE ALLEN WARE		d. STREET ADDRESS 38 Adams Street, N.W.	
3. NAME OF DECEASED (Type or print) CLYDE ALLEN WARE		4. DATE OF DEATH August 9, 1967	Month Day Year 19 19
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	NEVER MARRIED Divorced
8. DATE OF BIRTH May 9, 1925	9. AGE (In years last birthday) 42 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaping	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) South Carolina	
13. FATHER'S NAME Charlie Ware (D)	14. MOTHER'S MAIDEN NAME Ethel Ware (D)	12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 578-22-4874	17. INFORMANT VA Records, VAH Perry Point, Md.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, acute hemorrhagic, both lower lobes DUE TO lower lobes 2-4 days 5811 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Pancreatitis, hemorrhagic, acute DUE TO Peripancreatic fat necrosis 2-4 days stating the underlying cause lost. (c) Laennec's cirrhosis, severe 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----
21. I certify that (I) (this hospital) opened his/her body July 19, 1967 , to August 9, 1967 , the dead person saw the deceased alive on August 9, 1967 , and that death occurred at 7:50 AM from causes and on the date stated above.		20f. (City or town) ----- (County) ----- (State) -----	
22a. SIGNATURE <i>S. Goldgraben</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. S. Goldgraben, M.D.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 8-9-67
22c. PHYSICIAN'S NAME (Type) S. Goldgraben, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md. 21902	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/14/1967	23c. NAME OF CEMETERY OR CREMATORIAL Harmony
24. FUNERAL DIRECTOR Malbert Stewart		ADDRESS 1432 1/2 St. NW	25a. REC'D BY REGISTRAR Charles J. Jagger
		Jarvis Funeral Home, Washington, DC	25b. REGISTRAR'S SIGNATURE AUG 14 1967



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

10924

FOR STATE
HEALTH DEPT.

er death. If any delay is
Give Pages 1, 2 and 3 to
ing with farm PM3. Page

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, on the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with Health prior to burial, cremation or removal, and in any event within 72 hours after death.

→ may be retained for 10 years.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <i>Cecil</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Elkton</i>		c. LENGTH OF STAY IN lb <i>1 hour</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Elkton</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>R.D. 1 (Circus Park)</i>		e. STREET ADDRESS <i>R.D. 1 (Rte. 7)</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Rickie Allen Whited</i>		First <i>Rickie</i>	Middle <i>Allen</i>	Last <i>Whited</i>	4. DATE OF DEATH <i>8 - 17 1967</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>1-12-64</i>	9. AGE (In years lost birthday) <i>3 yrs.</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>child</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>John Henry Whited</i>		14. MOTHER'S MAIDEN NAME <i>Helen Frances Cooper</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Trooper D.C. Hash, Md. State Police</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Asphyxia due to drowning</i>				Address <i>North East, Md.</i>	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. <i>9290</i>		DUE TO (b) <i>Drowning</i>	DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <i>Unk.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20c. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>Fell into septic tank pit, full of water (8' deep)</i>			
20c. TIME OF INJURY Month, Day, Year Hour <i>12:15</i> p.m. <i>8-17 1967</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Yard nr. home</i>	20f. (City or town) <i>Rte. 7 (Circus Park) (Cecil), Md.</i>	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John M. Byers</i> EXAMINER'S NAME (Type) <i>John M. Byers, M.D.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/20/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Clinch Valley Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Richlands, Va.</i>	
24. FUNERAL DIRECTOR <i>Ralph E. Hicks</i>		25a. REC'D BY REGISTRAR <i>AUG 24 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
Hicks Home for Funerals, Elkton, Md.					

analyse

reduced connective tissue

disorders

• by rhomboid-shaped yellow monili - ~~spores~~ - faint

• in bottom of clefts of mucous membrane

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G392 8728767 ph

10925

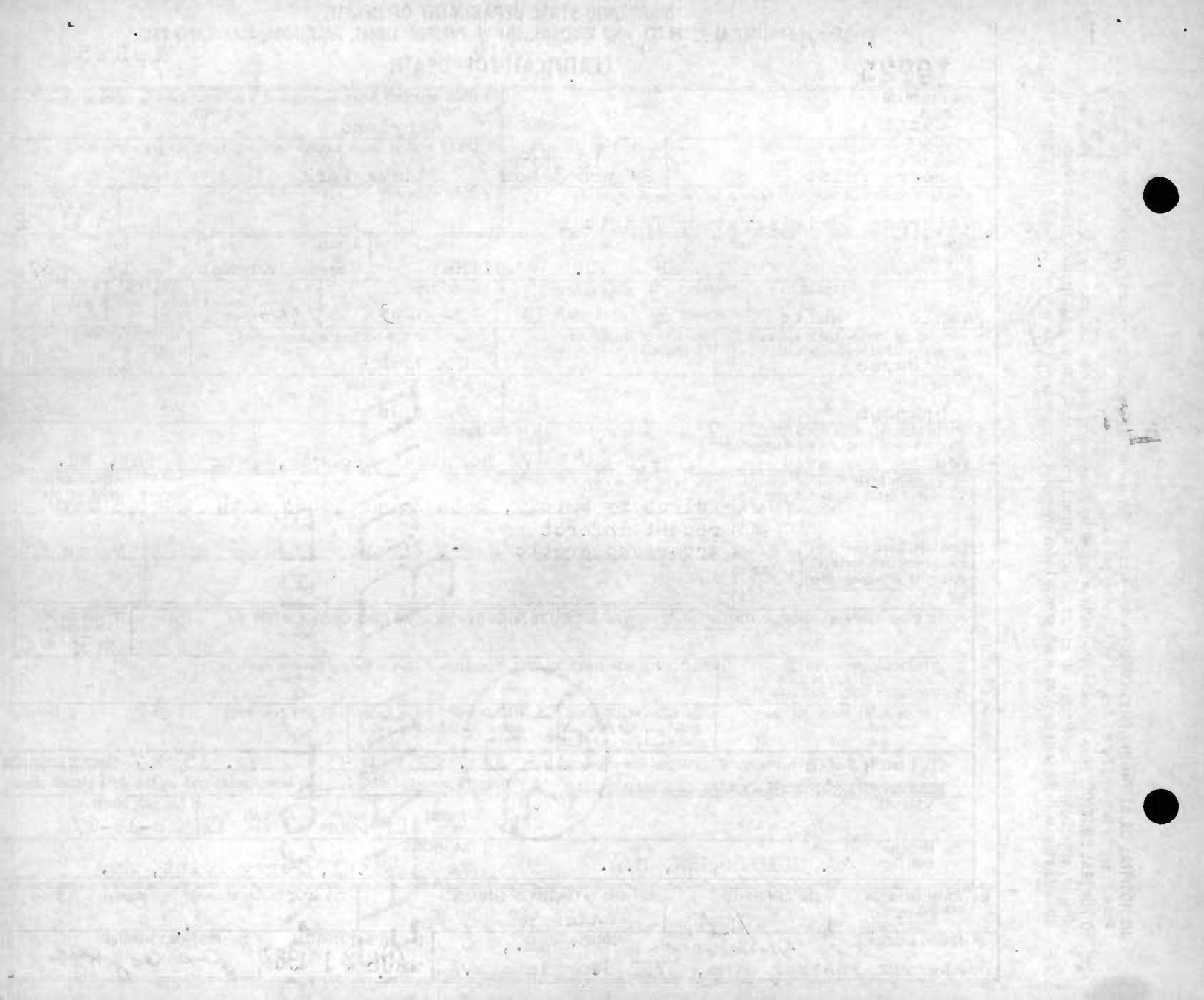
CERTIFICATE OF DEATH

10925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~seal~~ ^{use} carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 16 24 yrs 12 days 3 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First WINIFRED	Middle S.	Lost	4. DATE OF DEATH August 15 1967	Month August	Day 15	Year 1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-92	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (County & State, or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. WW I 479-28-6183		17. INFORMANT VA Hospital Records, Perry Point, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emboli, both lower lobes with</u> <u>4200</u> DUE TO <u>recent infarct</u>						INTERVAL BETWEEN ONSET AND DEATH 3 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)						years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 22, 1943, to Aug. 15, 1967, that he was not seen since the deceased died on on XXXXXX and that death occurred at 8:10 M from causes and on the date stated above.								
22a. SIGNATURE <u>Spelman</u>						22b. DATE SIGNED 8-15-67		
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF 8/17/67		23c. NAME OF CEMETERY OR CREMATORIAL Wilmington Cem		23d. LOCATION (City or Town) (County) (State) Wilmington		
24. FUNERAL DIRECTOR <u>Huntmann</u>		ADDRESS Wash., DC		25a. REC'D BY REGISTRAR AUG 21 1967		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
Huntemann Funeral Home, 5732 Georgia Ave. NW								



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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10926

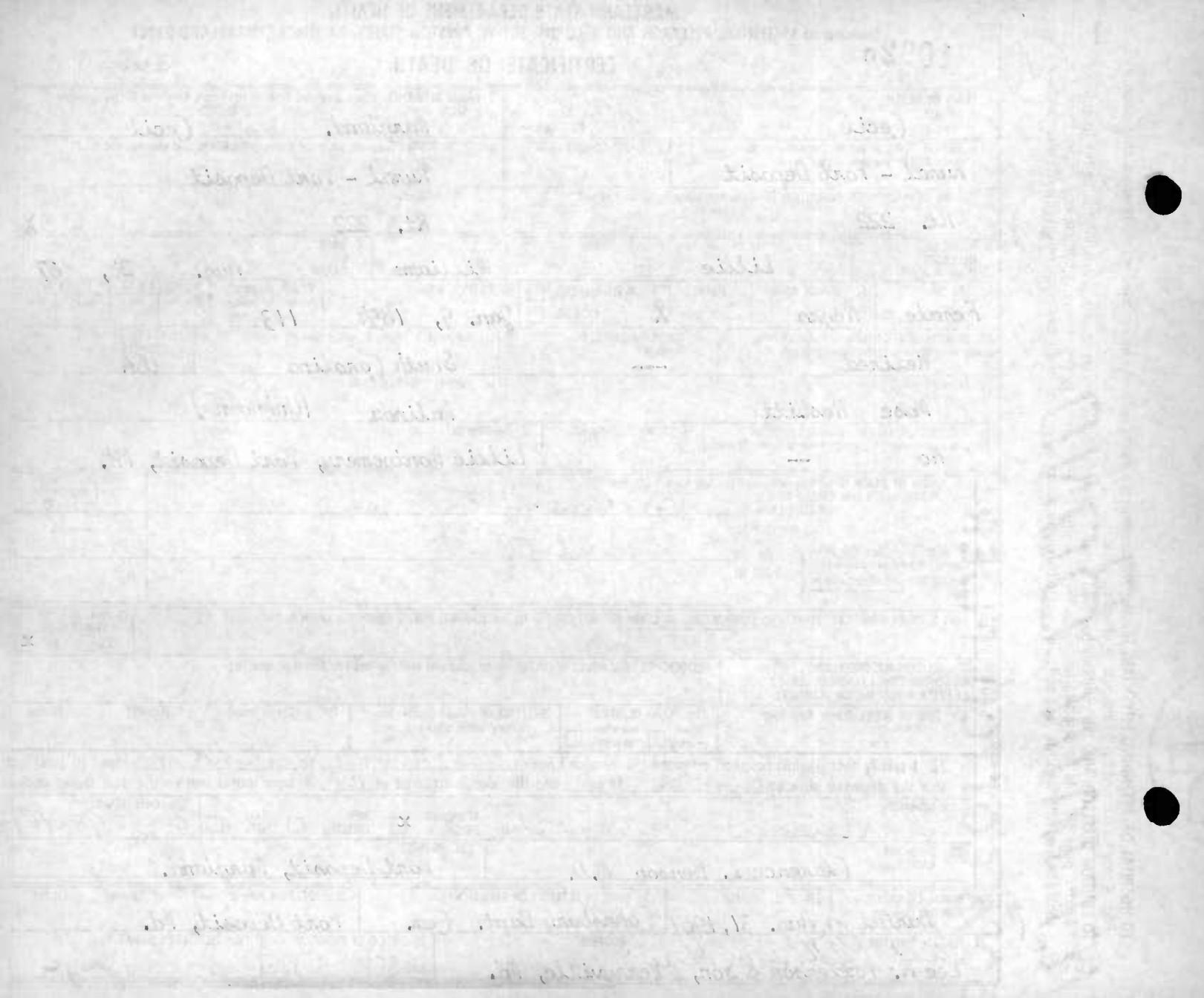
CERTIFICATE OF DEATH

10926

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Port Deposit</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Port Deposit</i>		
c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Rt. 222</i>			d. STREET ADDRESS <i>Rt. 222</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Lillie</i>			4. DATE OF DEATH Month <i>Aug.</i> Day <i>28,</i> Year <i>1967</i>	Doy	Year
S. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 9, 1854</i>	9. AGE (In years last birthday) <i>113 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		
11. BIRTHPLACE (County & State, or foreign country) <i>South Carolina</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Mose Nesbitt</i>			14. MOTHER'S MAIDEN NAME <i>Malinda (Unknown)</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>—</i>		
17. INFORMANT <i>Lillie Montgomery, Port Deposit, Md.</i>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocarditis</i> DUE TO <i>4222</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteritis</i> DUE TO (c) <i>—</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 24, 1967</i> , to <i>Aug 28, 1967</i> , that (I) (we) last saw the deceased alive on <i>Aug 28, 1967</i> , and that death occurred at <i>10P M</i> , from causes and on the date stated above.					
22a. MEDICAL CERTIFICATION 22b. SIGNATURE <i>Clarence J. Benson</i> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	DATE SIGNED <i>Aug 29-1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Clarence J. Benson M.D.</i>			22d. ADDRESS <i>Port Deposit, Maryland.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug. 31, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cokesbury Bapt. Cem.</i>	23d. LOCATION (City or Town) (County) (State) <i>Port Deposit, Md.</i>	
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Perryville, Md.</i>			ADDRESS	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE
			DATE <i>SEP 6 1967</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

10927

10927

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boulder Elkhorn		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Virginia Beach			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital (Elkhorn)				d. STREET ADDRESS 4132 First Court Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Otis Lee		First	Middle	Lost	4. DATE OF DEATH August 15, 1967	Month	Doy Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 30, 1934	9. AGE (In years lost birthday) 32 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norfolk, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Cecil C. Williams		14. MOTHER'S MAIDEN NAME Ethel Asble					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Cecil C. Williams same address		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Bilateral Bronchopneumonia complicating Multiple XMKK Injuries						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. 802 X		(b) DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Subj. struck by train		20c. TIME OF INJURY Month, Day, Year Hour o.m. 7 XX 8/12 1967		20d. INJURY OCCURRED While Not While of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RR Tracks		20f. (City or town) (County) (State) Baltimore, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 8/15/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 8/26/67		23c. NAME OF CEMETERY OR CREMATORIAL Rosewood Memorial Park Cemetery		23d. LOCATION (City or Town) (County) (State) Va. Beach, Virginia	
24. FUNERAL DIRECTOR Wm. T. Zimmerman		ADDRESS Bullock, Va.		25a. REC'D BY REGISTRAR AUG 31 1967		25b. REGISTRAR'S SIGNATURE Charles J. George	

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